TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, May 23, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

ILEOTOMY FOR DIFFUSE CARCINOMATOUS INFILTRATION OF THE COLON.

DR. CHARLES K. BRIDDON presented a patient, a man, thirty-four years of age, who, twelve years ago, began to be troubled with constipation, painful defecation, with occasional bleeding, some rectal tenesmus, and piles. This condition continued—now better, now worse—for two years, his constipation, however, being succeeded by more or less diarrhœa. He was then operated on in the New York Hospital for what his doctors told him was "stricture of the rectum." Two years later, in 1887, his symptoms still persisting, they advised him to have an artificial anus made. He did not consent to it. Since then he has continued to be troubled, more or less all the time, with diarrhœa, occasional bleeding, not very much pain, but a dull ache in the left inguinal region present most of the time, especially for the last three months. He affirms that in the summer he loses weight, but that in the winter he always picks up again. He has gained weight since last September.

When admitted to the Presbyterian Hospital, April 12, 1894, his appetite was good. He had six to eight dejections a day, which were loose, containing blood and mucus and were offensive. Rectal examination—the patient being in the knee-chest position—was negative. While the patient is sitting or lying down, however (on his side), an indurated, ulcerated mass could be felt about six inches up the rectum. Following the examining finger came stinking, chocolate-looking, bloody *débris*.

An attempt was first made to do a left inguinal colotomy. In this region, however, the colon was found to be thickened by general

infiltration, and to be so bound down to the posterior wall of the abdomen that it was found impossible to bring the altered colon into the wound. The tumor reached up as far as the examining finger could go.

An attempt was then made to create an artificial anus on the right side by bringing up the cæcum at that point. It, too, was found to be the seat of the same growth. From this the whole colon was judged to be the seat of similar trouble, and it was deemed useless to open it anywhere in its course. The ileum was then sought for. It was found to be healthy, and was, therefore, brought up into the wound two or three inches from its termination in the ileo-cæcal valve, and stitched to the abdominal wall.

The gut was opened on the third day. Since then it has been discharging steadily at intervals. The opening remains patent. The man still has considerable bloody discharge from the rectum, of offensive odor, the same mass can be felt by rectum. The patient's general condition is much as before except that the operation has relieved him almost entirely of his pain.

Dr. Briddon had not been able to find a record of any such general infiltration of the coils of the large intestine as were found in this case. On first exposing the sigmoid, its coats were found uniformly involved; drawing down the descending colon, it could be examined as far as the splenic flexure, and similar conditions found; traced downward, the thickening gradually increased, terminating in a hard cartilaginous mass in the cavity of the pelvis. On making the section on the right side, the cæcum was found in the same condition and drawn upward, as if by shortening of the whole length of the colon.

There was no papillomatous condition. The colon was infiltrated with pinkish-colored nodules, looking like grains of boiled sago, but quite unlike the infiltration of miliary tuberculosis. He had seen a similar condition in the stomach four or five years ago. The patient, a colored woman, had a movable tumor, supposed by some who had seen her to be a floating kidney. It lay just above the umbilicus, and could be pressed into the locality of the right kidney. Dr. Briddon made abdominal section and found the tumor to be the stomach, about the size of a large cocoanut, its walls, except at the greater curvature and pylorus, being infiltrated to the thickness of three inches, its attachments so long that he was able to lift it entirely out of the abdomen. Underneath the peritoneum was the finely granular condition seen in the patient just presented. The gastro-

hepatic omentum was also implicated in the disease. Although the operation proved to be only exploratory, the patient's condition was improved greatly at the end of three months, when she left the hospital. Dr. Briddon added that there could be no doubt of the malignant character of the case now presented, the appearance of the colon and the hard mass felt in the rectum pointed clearly to that diagnosis.

EPITHELIOMA INVOLVING FRONTAL SINUS AND NOSE.

Dr. W. W. Van Arsdale presented a man fifty-seven years of age, who fourteen years ago first noticed a small purplish spot on the nose, which was generally covered with a scab. Six years ago this was cut out. Two years afterwards it returned and went on to slowly increase in size until one year ago when it spread rapidly. At that time, June 13, 1893, the patient entered the New York Cancer Hospital, and was operated upon by Dr. B. F. Curtis, who removed a large ovoid growth reaching from the nasal eminence of the frontal bone to within three-fourths of an inch of the tip of the nose. Later, July 17, Dr. Van Arsdale, having charge of the ward, performed a rhinoplastic operation, scraping the granulating wound with the curette, trimming the edges with the scissors, after which a large flap was turned down from the forehead and attached with fine silk. The pedicle of the flap was left attached nearly an inch above the inner angle of the left eye. The gap on the forehead was filled with skin grafts from the thigh under dressing with sterilized normal salt solution and rubber tissue. The dressing was changed on the 20th; on the 26th all the grafts had taken on the forehead, and August 7 the man was discharged, an opening, leading to the frontal sinus, having been left near the canthus of the right eye. This opening constituted the only unusual feature in the case, and was left in order to furnish ready access to the frontal sinus should recurrence take place. Thus far there had been no recurrence, and the cosmetic effects of the operation had also been of the most satisfactory kind.

Dr. B. F. Curtis remarked that the most interesting point in this case seemed to him to lie in the fact that at the time of the first operation about two teaspoonfuls of epitheliomatous material were curetted from the frontal sinus, the small bones of the nose were removed in the same way, yet there had, after this length of time, been no evidence of recurrence. If the parts retained their healthy appearance until next fall, he would feel encouraged to close the opening leading into the frontal sinus. As was well known, recur-

rence was apt to take place rapidly where the frontal sinus was involved by malignant disease.

TUBERCULOSIS OF THE BREAST.

DR. CHARLES A. POWERS read the paper of the evening upon this subject. (See p. 159.)

DR. BRIDDON inquired of Dr. Powers whether in any of the cases infection of the breast had been traced to the nursing tuberculous child, and receiving a negative reply, added that while he had seen no cases himself, yet the possibility of infection from that source seemed reasonable when one considered the number of tuberculous babies with sore mouths and mothers with sore nipples.

NEPHRECTOMY.

DR. BRIDDON presented a kidney removed from a patient who had suffered from symptoms of renal calculus for several years, and who was subjected to the operation of nephrolithotomy in the Presbyterian Hospital, in the month of January, 1894, when a large stone was removed from the pelvis of the kidney; the general condition of the patient was very much improved, but he continued to discharge a considerable quantity of urine through the aperture in his loin; sometimes it would cease for a few days when a 1-per-cent. solution of creolin injected through the fistulous opening communicating with the ureter passed into the bladder; more often this channel was closed and the urine passed through the operation wound and was a source of much annoyance. After waiting four months, it was determined to remove the kidney; and the operator said it was the most difficult nephrectomy he had ever performed; vertical and transverse incisions gave ample room; the cicatricial tissue was so dense that digital enucleation had to be supplemented at almost every step by the knife and scissors. The dissection was carried first to the inner side of the fistulous track, and below the quadratus, until the posterior surface was found at a considerable depth; and the pale color of the organ made it difficult to distinguish it from the surrounding condensed fatty tissue; then it was separated externally and in front, where the colon was found intimately adherent. The ureter was first isolated and ligatured at its junction with the pelvis, then the vein and artery were each secured with a separate ligature. Up to the present date the after-history had been uneventful.

The specimen illustrated the advanced condition of a dilated and chronically-diseased kidney; the pelvis in which the calculus lodged and the calyces had contracted after the first operation; but the evidences of dilatation and thickening of their coats were sufficiently well marked; there was little renal tissue to be recognized by the naked eye, but there was sufficient to keep up a very annoying discharge.

INTUSSUSCEPTION; DEATH AFTER LAPAROTOMY; REDUCTION.

DR. BRIDDON reported the following case of intussusception: The patient was a small infant, eight months of age, who entered the Presbyterian Hospital on the afternoon of May 10, 1894.

It had been apparently perfectly well until twenty-four hours before; had been playing with other children in the morning; after this had slept for several hours, waking up suddenly with considerable abdominal pain followed in a short while by vomiting; a few hours later it had a stool which the parents say was perfectly normal. The pain kept up, and in the evening it had a bloody dejection, followed by others in the course of the night and the next morning. Each time the baby was nursed it would vomit.

From the history a diagnosis of intussusception was made, and operation advised. There was no protrusion from anal orifice, but a mass could be made out by the examining finger three to four inches up the rectum. By abdominal palpation also a firm, sausage-shaped mass could be made out running from the ribs to the brim of the pelvis on the left side. Under chloroform a median incision about six inches long, with its centre about at umbilicus, was made. The cæcum was sought for by following up the distended large intestine. This was found to be the seat of the trouble. The whole length of the colon seemed to be filled by the invaginated portion; while the finger of the assistant was passed through the anus and exerted pressure on the gut in the rectum by manipulation of the exposed colon, the invaginated mass was easily forced up to the immediate neighborhood of the constriction, but beyond this it could not be made to go.

During this process the invaginated portion could be plainly seen through the distended coats of the large intestine, sliding by as it was pushed up more and more in the direction of the ileo-cæcal valve. As well as could be ascertained, the neck of the intussuscipiens was situate at about the hepatic flexure.

Attempts at reduction by compression applied from below proving ineffectual, slight traction was resorted to, applied to the small intestine above. Such traction, however, of the internal cylinder, as the unpromising condition of the parts seemed to warrant, appeared to exercise no influence in the direction of delivery, and only after gentle dilatation of the sheath was the sudden release effected by the combined action of compression and traction. The part that had resisted almost all efforts at reduction was the invaginated cæcum, the walls of which were almost black, fading into a dark maroon color, and converted into a solid mass by the infiltration of its walls with coagulated blood. The application of hot towels to the gut pending the introduction of sutures into the abdominal walls improved its condition sufficiently to warrant its return.

Dr. Briddon added that the intussuscepting portion of the gut was very much dilated, its diameter being about that of a drinking-glass, its walls so thin that the intussuscepted part could be seen moving up and down within. Notwithstanding its extreme thinness, the only way in which reduction could be effected was by further dilatation with the finger and pressure. Of course this was made with care, and would have been more dangerous had the condition not been of so short duration. The dark-colored portion of gut soon took on a lighter hue, showing that it was due to stagnation of blood and not to gangrene, and was then returned to the abdomen. The child was already in collapse, but lived four or five hours.

DR. ABBE was reminded by Dr. Briddon's case of one seen by himself about a year ago, in which he operated about sixteen hours after the intussusception occurred. The tumefaction was so great that it was impossible to effect reduction of the colon until the stretching process had been continued for some time. The adhesions between the layers of gut were much stronger than one would suppose could take place in so short a time. Although the reduction was finally complete, the child died within twenty-four hours. A similar experience with a man, in whom, however, the parts had gone to the extent of sloughing, led Dr. Abbe to feel that it might be safer to make an artificial anus, and later to deal further with the case as the circumstances might demand.

DR. BRIDDON thought it would have taken as long to make an artificial anus in his case as to reduce the invagination. Probably not more than five minutes were spent in handling the gut.

DR. DAWBARN, referring to milder cases of intussusception in

which other measures than laparotomy were considered first, said he had tried a device which, while it may have been recorded before, was new to him,—namely, the introduction of water impregnated with carbonic acid gas through a Nélaton catheter placed over the siphon of a fountain. In one case, that of a child, the method succeeded nicely; in another, it failed completely to make reduction. In the latter he then operated, and although not more than five minutes were consumed, the child died. Recently, a physician from the South had told him that he was present in Richmond at a case of intussusception in an adult when a surgeon was about to operate, and a gentleman present suggested that injection of glycerin be tried. After hesitating a moment the surgeon agreed to this proposition. The patient was placed in Trendelenburg's posture, and a quart and a half of glycerin was introduced into the rectum. After half an hour the recumbent posture was restored, and the gut emptied itself with great noise, showing that reduction had been effected. As to making an artificial anus, he thought Maunsell's operation could be performed in half the time, and save a second operation.

DR. BRIDDON said he was in the habit of first trying reduction of the intussusception by inverting the patient and injecting water, and had seen it succeed; but in the present case he thought the condition found at the operation proved conclusively that it would have been a dangerous procedure. While he would admit the propriety of trying reduction by water introduced into the rectum, he did not think he would ever use gas.

DR. DAWBARN remarked that it was well known there was good authority for using gas as well as for using water. He agreed with Dr. Briddon, that in his case it probably would have been unsafe. It should be used with the utmost caution in any case. He knew of no means by which the force of gas could be more accurately adjusted than by the trigger of the siphon.

DR. CURTIS believed the use of the siphon had been condemned by all writers, and ought to be condemned by this society. He regarded it himself as a very dangerous method. The pressure within the siphon was tremendous, something like 200 pounds to the square inch, he believed. Of course it was possible to introduce a small quantity of the gas at a time, but it was impossible to say how much was the pressure in the lower part of the gut unless the obstruction had been overcome, and there was equal distention throughout its entire length. The only safe method, the one which would enable

the physician to accurately estimate the amount of hydrostatic pressure, was that of connecting the rectal tube with a fountain elevated a known distance above the patient. A fall of about fifteen feet would give a pressure of eighty pounds to the square inch, which might be used with safety in the adult. In the child a much lower fall was to be used. As to the siphon, it was little in advance of the suggestion made by the older surgeons, to introduce an effervescing powder into the bowel.

DR. BRIDDON remarked that he had never seen a case of intussusception in a child under a year old recover.

DR. ABBE had seen a very striking case of intussusception two years ago with Dr. Holt, which was relieved by hydrostatic pressure, the pail being lifted about five feet above the inverted child. He learned from Dr. Holt that the same child had intussusception again a year afterwards and died.

DR. VAN ARSDALE mentioned a case of intussusception in a child under a year of age which was treated as Dr. Abbe had proposed, by making an artificial anus, but it died. In two other cases treated in St. Elizabeth's Hospital the same year, one was operated upon, and reduction effected within about six hours, the other within twenty-four hours, but both patients died shortly afterwards. He thought death in such cases was usually due to the effects of the intussusception itself, not to the operation.

DR. DAWBARN thought that, in view of the vigorous reverse peristalsis produced by chloride of sodium and carbonate of sodium, as shown by Nothnagel's experiments, it might aid the mechanical effects of the injected water in effecting reduction of the intussusception to add to it one or other of these agents.